MDR Tracking Number: M5-04-1344-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-15-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic procedures, application modalities, interactive individual medical psychotherapy and therapeutic exercises on 05-07-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for date of service 05-07-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Finding and Decision is hereby issued this 30th day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

January 26, 2004 **Amended January 29, 2004**

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified in Psychiatry and a licensed Doctor of Chiropractic under his direction. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ injured his back while lifting a trashcan on ___. He had a history of prior knee surgery for another work-related injury. His back pain has been recalcitrant to both extensive conservative and surgical interventions. From the records available for review, there were notations of depression complaints as 1/16/02. He had back surgery on 3/7/02 and apparently there was initial relief of his pain and mood symptoms. However, the pain recurred. His course was complicated by a month-long hospitalization for sepsis related to a tooth abscess.

Subsequent to this hospitalization, ___evaluated him. ___felt that this patient had depression and noted poor motivation, poor sleep and weight loss. Zoloft was initiated, as was individual therapy two times per week.

On 3/24/03, the therapy frequency was reduced to once per week, but again increased to twice weekly on 4/3/03. On 5/1/03, ___increased the frequency of therapy to three times a week. He also recommended a chronic pain management program that was apparently not approved.

The reviewer notes that if all of the individual therapy notes were included, it appears that this patient was either not getting therapy with the recommended frequency or that he was not attending at the recommended intervals. In particular, there is no note documenting the service on the date in dispute. The included notes indicate that the individual therapy was primarily supportive in nature. ___ has continued in therapy and continues to have persistent depression symptoms including violent and suicidal ideations. Medication doses have been adjusted; however, he has had difficulty obtaining his prescriptions. There are some inconsistencies between the objective signs and subjective symptoms.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic procedures, therapeutic exercises, application modalities and interactive individual medical psychotherapy.

DECISION

The reviewers agree with the prior adverse determination.

BASIS FOR THE DECISION

There are a number of issues that are relevant to this case which were not addressed by the records provided for review. The first question is whether the service actually occurred, as there is not documentation of this interaction in the notes. Obviously, if no service was provided, it should not be covered.

The second issue is what was the actual frequency that therapy was being provided. Given the degree of symptoms documented in the notes closest to the date of service in question, three individual supportive psychotherapy sessions per week as were recommended by the treating physician would have been excessive. If the carrier had covered one or two other sessions that week, the reviewer would not recommend covering another session.

The third issue is that the treatment goals are poorly defined in the documentation. While it does appear that this gentleman was depressed and likely needed medications and therapy around the disputed date of service, there is not a comprehensive assessment provided with the included documentation, there are minimal objective measures of symptoms documented, and there are not clearly defined treatment goals to justify the provided services.

With regards to the therapeutic procedures and the application of modalities, the carrier's representative presented compelling arguments regarding the lack of necessity of ongoing care in this setting. There was no evidence presented by the treating provider that the care rendered was beneficial to the patient's ability to return to work or to relieve symptoms. While this patient was clearly injured, it was unclear from the documentation presented as to the goals of this treatment. As a result the chiropractic reviewer finds it was not medically necessary.

Overall, given the lack of documentation that the service was provided, the lack of clear objective treatment goals, and the probability that the frequency of the sessions was in excess of what was actually necessary, the reviewer finds that the services in dispute were neither medically necessary nor appropriate.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,